ARKANSAS DEPARTMENT OF HUMAN SERVICES

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MEMORANDUM

TO: Arkansas Medicaid Enrolled Prescribing Providers and Pharmacy Providers

FROM: Cynthia Neuhofel, Pharm.D. Division of Medical Services Pharmacy Program

DATE: August 25, 2021

SUBJ: **AR Medicaid Prior Authorization Edits approved at the AR Medicaid DUR Board July 21, 2021 meeting for the following:**
Manual review criteria for: Hetlioz® (tasimelteon), Verquvo™ (vericiguat), Fotivda® (tivozanib), Lumakras™ (sotorasib), Empaveli™ (pegcetacoplan), and Truseltiq™ (infigratinib)

Point-of-Sale edits for: Update for ADHD medications, ICS-LABA for asthma, Lyrica® (pregabalin), soft ProDUR edits for opioids combined with benzodiazepines, sedative hypnotics, muscle relaxers, antipsychotics, or gabapentin.

General criteria info: New-to-market medications and medications with label expansions

Preferred Drug List (PDL) therapeutic classes: (August 11, 2021 Drug Review Committee meeting)
Alzheimer's agents, benign prostatic hyperplasia agents (BPN), hemorrhoidal preparations, opiate dependence treatments (oral buprenorphine products only), and skeletal muscle relaxants

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I. ANNOUNCEMENTS

A. PLACE OF SERVICE

General Information

Arkansas Medicaid is updating the National Place of Service Code in the Pharmacy manual and in the billing rules to comply with the national standards, and to ensure pharmacies are billing consistently. Effective 8/1/2021, the current code of "99" will be replaced with the correct Place of Service Code for Pharmacy "01".

If you have questions regarding this notice, please contact the Provider Assistance Center at 1-800-457-4454 toll-free or locally at (501) 376-2211. If you need this material in an alternative format, such as large print, please contact the Office of Rules Promulgation at (501) 396-6428.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making, and remittance advice (RA) messages are available for download from the Division of Medical Services website.

B. COVID-19 VACCINATION UPDATED RATES AND BILLING CODES

Due to the continuing Public Health Emergency (PHE), Arkansas Medicaid, in conjunction with the Office of the Governor of the State of Arkansas, has authorized a temporary increase in the reimbursement rate for administration of 1st and 2nd COVID-19 vaccine doses. This temporary increase is in effect for 60 days, starting Friday, August 13th, 2021 and ending Monday, October 11th, 2021. The temporary administration rate has increased to $100.00 for procedure codes 0001A and 0002A (Pfizer 1st and 2nd shot) and 0011A and 0012A (Moderna 1st and 2nd shot) and 0031A (Johnson & Johnson single shot). The procedure codes for 91300, 91301 and 91303 for the vaccine alone will remain the same. The 3rd dose for Pfizer and Moderna for qualified clients will continue with a $40.00 administration rate.

***These new rates were effective as of 3/15/2021 for 0001A, 0002A, 0011A, and 0012A. Beginning 8/12/2021, the third dose of Pfizer and Moderna COVID-19 vaccinations with codes 0003A and 0013A became effective.**

***Review the Department of Human Services COVID response page for updates to any new billing guidance. Updates for Providers - Arkansas Department of Human Services**

CODE	SHORT DESCRIPTION	LABELER NAME	FEE
91300	SARSCOV2 VAC 30MCG/0.3ML IM	PFIZER-BIONTECH	$0.01
0001A	ADM SARSCOV2 30MCG/0.3ML 1ST	PFIZER-BIONTECH	$40.00
0002A	ADM SARSCOV2 30MCG/0.3ML 2ND	PFIZER-BIONTECH	$40.00
0003A	ADM SARSCOV2 30MCG/0.3ML 3RD	PFIZER-BIONTECH	$40.00
91301	SARSCOV2 VAC 100MCG/0.5ML IM	MODERNA	$0.01
0011A	ADM SARSCOV2 100MCG/0.5ML 1ST	MODERNA	$40.00
0012A	ADM SARSCOV2 100MCG/0.5ML 2ND	MODERNA	$40.00
0013A	ADM SARSCOV2 100MCG/0.5ML 3RD	MODERNA	$40.00
91303	SARSCOV2 VAC AD26 .5ML IM	JANSSEN	$0.01
0031A	ADM SARSCOV2 VAC AD26 .5ML	JANSSEN	$40.00

C. UPDATE FOR DECLARATION OF PUBLIC HEALTH EMERGENCY FOR COVID-19

The Governor announced that the public health emergency expired on May 30, 2021. Due to the COVID-19 emergency, Arkansas Medicaid relaxed some pharmacy edits to accommodate the special needs during this time. Now that the public health emergency is ending, previous edits were reinstated beginning August 1, 2021.

- The early refill (ER) edit and the “Refill Too Soon” Accumulation Logic will be reinstated.
- Pharmacy providers will no longer be allowed to bypass the early refill ProDUR alert for
- non-controlled prescriptions.
- The aerochamber pharmacy restriction allowing 1 per year will be reinstated.
- All short-acting beta agonists have been available without a PA. The following preferred
- drug list will be reinstated.

Preferred Short Acting Beta Agonists agents

- Albuterol HFA (ProAir HFA- BRAND ONLY)
- Albuterol HFA (Proventil HFA-BRAND ONLY)
- Albuterol sulfate 0.63mg/3ml solution
- Albuterol sulfate 1.25mg/3ml solution
- Albuterol sulfate 2.5mg/0.5ml solution
- Albuterol sulfate 2.5mg/3ml solution
- Albuterol sulfate 5mg/ml solution

Nonpreferred Short Acting Beta Agonists agents

- Albuterol HFA (generics, Ventolin)
- Albuterol sulfate inhalation powder (ProAir RespiClick, ProAir Digihaler)
- Levalbuterol inhalation solution (Xopenex inhalation solution)
- Levalbuterol HFA inhaler (Xopenex HFA)

D. ARKANSAS LEGISLATION 2021 ACT 357

Effective 10/1/2021, Arkansas Medicaid will allow all prescription eye drops to refill after 70% of utilization has passed. Prescription eye drops can be refilled after twenty-two (22) days have passed since last fill.

EFFECTIVE OCTOBER 1, 2021:

II. PREFERRED DRUG LIST (PDL):

****Bolded medications have had a change in status.****

1) ALZHEIMER'S AGENTS

PREFERRED AGENTS

- Donepezil tablet (generic for Aricept®)
- Exelon® patch (rivastigmine)—**BRAND ONLY**
- Memantine tablet (generic for Namenda®)

NONPREFERRED AGENTS

- Aricept® tablet (donepezil)
- Donepezil ODT (generic for Aricept® ODT)
- Donepezil 23 mg tablet (generic for Aricept®)
- Galantamine tablet (generic for Razadyne®)
- Galantamine ER capsule (generic for Razadyne® ER)
- Galantamine solution (generic for Razadyne®)
- Memantine ER capsule (generic for Namenda® XR)
- Memantine solution (generic for Namenda®)
- Namenda® XR capsule (memantine ER)
- Namenda® tablet (memantine)
- Namzaric® capsule (memantine/donepezil)
- Razadyne® ER capsule (galantamine)
- Rivastigmine patch (generic for Exelon®)
- Rivastigmine capsule (generic for Exelon®)

2) BENIGN PROSTATIC HYPERPLASIA AGENTS

PREFERRED AGENTS

- Alfuzosin ER tablet (generic for Uroxatral®)
- **Doxazosin tablet (generic for Cardura®)**
- **Dutasteride capsule (generic for Avodart®)**
- Finasteride tablet (generic for Proscar®)******
- Tamsulosin capsule (generic for Flomax®)
- **Terazosin tablet (generic for Hytrin®)**

NONPREFERRED AGENTS

- Avodart® capsule (dutasteride)
- Cardura® tablet (doxazosin)
- Cardura® XL tablet (doxazosin)
- Cialis® tablet (tadalafil)**‡**
- Dutasteride/Tamsulosin capsule (generic for Jalyn®)
- Flomax® capsule (tamsulosin)
- Jalyn® capsule (dutasteride/tamsulosin)
- Proscar® tablet (finasteride)
- Rapaflo® capsule (silodosin)
- Silodosin capsule (generic for Rapaflo®)
- Tadalafil tablet (generic for Cialis®)**‡**

****Diagnosis of Benign Prostatic Hypertrophy in the past 3 years**
‡Denial for diagnosis of erectile dysfunction

3) HEMORRHOIDAL PREPARATIONS

PREFERRED AGENTS

- Hydrocortisone 1% cream
- Hydrocortisone 2.5% cream
- Hydrocortisone/Pramoxine 1-1% cream
- Hydrocortisone/Pramoxine 2.5-1% cream
- Proctofoam-HC 1-1%
- Procto-Med HC 2.5% cream
- Procto-Sol HC 2.5% cream

NONPREFERRED AGENTS

- Anu-Sol HC 2.5% cream
- Proctozone-HC 2.5% cream

4) OPIATE DEPENDENCE TREATMENTS (oral buprenorphine products only)

PREFERRED AGENTS

- Buprenorphine SL tablets (generic for Subutex®)
- Suboxone® film (buprenorphine/naloxone)—**BRAND ONLY**
- **Zubsolv® SL tablets (buprenorphine/naloxone)**

NONPREFERRED AGENTS

- Buprenorphine/Naloxone film (generic for Suboxone®)
- Buprenorphine/Naloxone SL tablet (generic for Suboxone®)

5) SKELETAL MUSCLE RELAXANTS

PREFERRED AGENTS

- Baclofen tablet (generic for Lioresal®)
- Chlorzoxazone 500 mg tablet (generic for Parafon® Forte)
- Cyclobenzaprine 5 mg and 10 mg tablet (generic for Flexeril®)
- Methocarbamol tablet (generic for Robaxin®)
- **Skelaxin® tablet (metaxalone)—BRAND ONLY**
- Tizanidine tablet (generic for Zanaflex®)

NONPREFERRED AGENTS

- Amrix® ER capsule (cyclobenzaprine)
- Carisoprodol tablet (generic for Soma®)
- Carisoprodol/Aspirin (generic for Soma Compound®)
- Carisoprodol/Aspirin/Codeine (generic for Soma Compound® with codeine)
- Chlorzoxazone 375 mg and 750 mg tablet (generic for Lorzone®)
- Cyclobenzaprine 7.5mg tablet (generic for Fexmid®)
- Cyclobenzaprine ER capsule (Amrix®)
- Dantrium® capsule (dantrolene)
- Dantrolene capsule (generic for Dantrium®)
- Fexmid® tablet (cyclobenzaprine)
- Lorzone® tablet (chlorzoxazone)
- Metaxalone tablet (generic for Skelaxin®)
- Norgesic Forte® tablet (orphenadrine/aspirin/caffeine)
- Orphenadrine ER tablet (generic for Norflex®)
- Ozobax® solution (baclofen)
- Soma® tablet (carisoprodol)
- Tizanidine capsule (generic for Zanaflex®)
- Zanaflex® tablet and capsule (tizanidine)

III. PRIOR AUTHORIZATION DRUG CRITERIA (NEW OR REVISED):

EFFECTIVE OCTOBER 19, 2021

1) UPDATE FOR ADHD MEDS

As of 10/19/2021, the point-of-sale (POS) edits for ADHD medications have changed.

A. Recipients ≥ 19 years of age require a prior authorization request and a completed CII stimulant form. https://arkansas.magellanrx.com/client/docs/rxinfo/ARRx_SMN_Adult_C-II_Stimulant.pdf

B. Recipients < 6 years of age require a prior authorization request for all CII stimulants and atomoxetine.

C. The requirement for a billed diagnosis of ADHD will be removed effective 10/19/2021.

EFFECTIVE NOVEMBER 2, 2021

2) ASTHMA TREATMENT WITH ICS-LABA

	GINA (update 2021)	NIH (update 2020)
CHILDREN 0-4 (NIH) 0-5 (GINA)		
MILD	PRN SABA	PRN SABA OR LOW-DOSE ICS PLUS PRN SABA
MODERATE	LOW-MEDIUM DOSE ICS PLUS PRN SABA	MEDIUM-DOSE ICS PLUS PRN SABA OR MEDIUM-DOSE ICS-LABA PLUS PRN SABA
SEVERE	LOW-MEDIUM DOSE ICS PLUS PRN SABA; REFER TO SPECIALIST FOR ADD-ON THERAPY	HIGH-DOSE ICS-LABA PLUS PRN SABA; REFER TO SPECIALIST FOR ADD-ON THERAPY
CHILDREN 5-11 (NIH) 6-11 (GINA)		
MILD	PRN ICS PLUS PRN SABA OR LOW-DOSE ICS ± SABA	PRN SABA OR LOW-DOSE ICS PLUS PRN SABA
MODERATE	LOW-DOSE ICS-LABA PLUS PRN SABA, MEDIUM DOSE ICS PLUS PRN SABA OR LOW-DOSE ICS-LABA WITH PRN ICS-LABA	LOW-MEDIUM DOSE ICS-LABA WITH PRN ICS-LABA (age 4 and up)
SEVERE	MEDIUM-DOSE ICS-LABA, REFER TO SPECIALIST FOR ADD-ON THEARPY	HIGH-DOSE ICS-LABA PLUS PRN SABA, REFER TO SPECIALIST FOR ADD-ON THERAPY
ADOLESCENTS 12+ AND ADULTS		
MILD	PRN LOW-DOSE ICS-LABA	PRN SABA, LOW-DOSE ICS PLUS PRN SABA, OR PRN ICS WITH PRN SABA
MODERATE	LOW-MEDIUM DOSE ICS-LABA ± PRN ICS-LABA	LOW-MEDIUM DOSE ICS-LABA AND PRN ICS-LABA
SEVERE	POSSIBLY HIGH-DOSE ICS-LABA; REFER TO SPECIALIST FOR ADD-ON THERAPY	MEDIUM-HIGH DOSE ICS-LABA + LAMA AND PRN SABA, REFER TO SPECIALIST FOR ADD-ON THERAPY

Per NIH--ICS-formoterol should be administered as maintenance therapy with one to two puffs once to twice daily (depending on age, asthma severity, and ICS dose in the ICS-formoterol preparation) and one to two puffs as needed for asthma symptoms. The maximum number of puffs per day is 12 (54 mg formoterol) for individuals aged 12 years and older and 8 (36 mg formoterol) for children aged 4 to 11 years.

POINT-OF-SALE APPROVAL CRITERIA for Symbicort® and Dulera®:

****NOTE** Only Symbicort® and Dulera® may be used for SMART therapy.**

For Criterion 1: COPD diagnosis in the past two years **AND** ≥ 40 years old

OR

For Criterion 2: Paid drug claim in drug history for Advair Diskus®, Advair® HFA, Dulera®, or Symbicort® in the last six months

OR

For Criterion 3:

- Age ≥ 4 years of age; **AND**
- Asthma diagnosis billed in the past 2 years

OR

For Criterion 4:

- Age ≥ 4 years old; **AND**
- One of the following criteria below:
  - ≥ Three inhaled corticosteroid claims in the last 120 days; **OR**
  - ≥ Three oral steroid claims in the last 120 days; **OR**
  - Combination for ≥ three claims (as defined below) in the last 120 days:
    - o One Inhaled Corticosteroid + 2 Oral Steroids
    - o Two Inhaled Corticosteroids + 1 Oral Steroids

QUANTITY EDITS:
Symbicort®--#2 inhalers per month for 120 actuation size
If the recipient needs > 8 puffs per day, a PA can be submitted to approve an additional inhaler.

Dulera®–#2 inhalers per month

POINT-OF-SALE APPROVAL CRITERIA for Advair Diskus®

****NOTE** Advair Diskus® is not recommended for SMART therapy and should not be used for rescue.**

For Criterion 1: COPD diagnosis in the past two years **AND** ≥ 40 years old

OR

For Criterion 2: Paid drug claim in drug history for Advair Diskus®, Advair® HFA, Dulera®, or Symbicort® in the last six months

OR

For Criterion 3:

- Age ≥ 4 years of age; **AND**
- Asthma diagnosis billed in the past 2 years

OR

For Criterion 4:

- Age ≥ 4 years old; **AND**
- One of the following criteria below:
  - ≥ Three inhaled corticosteroid claims in the last 120 days; **OR**

• ≥ Three oral steroid claims in the last 120 days; **OR**
• Combination for ≥ three claims (as defined below) in the last 120 days:
  o One Inhaled Corticosteroid + 2 Oral Steroids
  o Two Inhaled Corticosteroids + 1 Oral Steroids

QUANTITY EDITS:
Advair Diskus®--#1 inhaler per month

EFFECTIVE IMMEDIATELY

3) HETLIOZ® (tasimelteon) 20 mg capsule and 4 mg/mL suspension

INDICATION:
HETLIOZ capsules
- Non-24-Hour Sleep-Wake Disorder (Non-24) in adults
- Nighttime sleep disturbances in Smith-Magenis Syndrome (SMS) in patients 16 years of age and older

HETLIOZ suspension
- Nighttime sleep disturbances in SMS in pediatric patients 3 years to 15 years of age

INFORMATION ON NON-24 HOUR SLEEP-WAKE DISORDER:
- Non-24-hour sleep-wake disorder (N24) is a circadian rhythm sleep disorder in which an individual's biological clock fails to synchronize to a 24-hour day. Instead of sleeping at roughly the same time every day, someone with N24 will typically find their sleep time gradually delaying by minutes to hours every day. They will sleep at later and later clock times until their sleep periods go all the way around the clock.
- The diagnosis requires a higher index of suspicion in sighted individuals, as N24SWD is rare in this population, particularly when compared with other more common causes of sleep-wake disturbances, such as chronic insomnia or delayed sleep-wake phase disorder (DSWPD).
- In blind individuals, treatment options include melatonin and melatonin receptor agonists. In sighted individuals, melatonin is typically used in combination with behavioral strategies, including appropriately timed light exposure.

INFORMATION ON SMITH-MAGENIS SYNDROME
Smith-Magenis syndrome (SMS) is a developmental disorder that affects many parts of the body. The major features of this condition include mild to moderate intellectual disability, delayed speech and language skills, distinctive facial features, sleep disturbances, and behavioral problems. Most people with SMS have a deletion of genetic material in each cell from a specific region of chromosome 17.

APPROVAL CRITERIA:
- Recipient with Non-24 diagnosis must be ≥ 18 years of age, and recipient with SMS diagnosis must be ≥ 3 years of age; **AND**
- Recipient must have a diagnosis of either Non-24-Hour Sleep-Wake Disorder **OR** Nighttime Sleep Disturbances in Smith-Magenis Syndrome **OR** a diagnosis consistent with FDA indications; **AND**
- Non-24-hour Sleep-Wake Disorder
  - Blind patient

        - Clinical trials provided in the package insert included totally blind patients and reference the Diagnostic and Statistical manual of Mental Disorders 5 (DSM-5) diagnostic criteria
            - A persistent or recurrent pattern of sleep disruption that is primarily due to an alteration of the circadian system or to a misalignment between the endogenous circadian rhythm and the sleep-wake schedule required by an individual's physical environment or social or professional schedule; **AND**
            - The sleep disruption leads to excessive sleepiness or insomnia, or both; **AND**
            - The sleep disturbance causes clinically significant distress or impairment in social, occupational, and other important areas of functioning; **AND**
        - Recipient must have tried and failed melatonin and other sleep aids
    - Sighted patient
        - Recipient must have tried and failed melatonin and other sleep aids; **AND**
        - Recipient must have tried and failed timed light exposure; **AND**
        - Sleep disturbance cannot be explained by other causes (i.e., neurological disorder, mental disorder, medication use, or substance use disorder)
- For Nighttime Sleep Disturbances in SMS requests:
    - Need confirmed diagnosis of SMS; **AND**
    - Need history of sleep disturbances; **AND**
- Prescriber must submit the following:
    - Current chart notes; **AND**
    - Documentation of medications and therapies tried to improve sleep patterns; **AND**
    - Documentation as listed above to confirm diagnosis; **AND**
    - Daily sleep logs or actigraphy for confirmation of sleep disruption; **AND**
- Initial PA for 3 months

DENIAL CRITERIA:

- Recipient does not meet approval criteria **OR** have a diagnosis supported in the official Compendia; **OR**
- Recipient requires the use of strong CYP1A2 inhibitors or strong CYP3A4 inducers; **OR**
- Recipient has severe hepatic impairment

CONTINUATION CRITERIA:

- Recipient has a positive response with nighttime total sleep time (increase) and daytime nap duration (decrease); **AND**
- Recipient is compliant on therapy; **AND**
- Prescriber must submit the following:
    - Current chart notes; **AND**
    - Documentation of response to therapy with daily sleep logs

QUANTITY EDITS:

20 mg capsules #31/ 31 days
Suspension 48 mL—3 bottles/ 31 days
158 mL—1 bottle/ 31 days

EFFECTIVE IMMEDIATELY

4) GENERAL CRITERIA FOR NEW-TO-MARKET PRODUCTS OR PRODUCTS WITH LABEL EXPANSIONS

Per Act 745 of the 2021 Arkansas legislative session:
https://www.arkleg.state.ar.us/Acts/FTPDocument?path=%2FACTS%2F2021R%2FPublic%2F&file=745.pdf&ddBienniumSession=2021%2F2021R

CRITERIA FOR MEDICATIONS NEW-TO-MARKET OR WITH LABEL EXPANSIONS

MANUAL GUIDELINES: Pertains to new-to-market FDA approved drugs available on the Medicaid drug file or drugs with a label expansion including new indication, dosage change, or age changes prior to being reviewed by the Arkansas Medicaid DUR Board.

APPROVAL CRITERIA:

- Medication must be an outpatient drug with a federal rebate agreement in place
- Medication must be prescribed for an FDA-approved indication with age, dose, and frequency based on manufacturer's packet insert
  - If the FDA-approved indication(s) does not match the client's diagnosis, the medication must have support for the requested diagnosis either in treatment guidelines or the official Compendia (MicroMedex®)
- If the new-to-market medication is included in an existing class/category on the preferred drug list (PDL):
  - The new-to-market medication will be added as a non-preferred option.
  - The new-to-market medication will require a prior authorization with documentation of the medical necessity over preferred options.
  - If the PDL class has multiple preferred options, the client must have documentation of trial and failure of at least 2 different chemical entities unless otherwise noted.
  - If the PDL class has multiple preferred options with multiple mechanisms of action (MOA), the client must have documentation of trial and failure from each MOA unless there is a contraindication.

    Example: Second generation antidepressants have multiple MOA as preferred option (i.e., SSRI, NSRI, and aminoketone).
- If the new-to-market medication's class/category is not on the preferred drug list (PDL), the documentation of medical necessity over older products in the same class is required along with a trial of at least 2 older products unless otherwise noted.
  - An exception—New-to-market antiepileptic drugs require a trial of 3-4 different AEDs available without a PA.
- If the new-to-market medication is the same chemical entity as another medication already on the market but in a different dosage form, the existing dosage form must be tried first. If the original medication was a solid oral dosage form, the following scenarios would require a prior authorization with documentation of the medical necessity for the new formulation.
  - New-to-market is an oral, non-solid dosage form (may be considered in clients <7 years of age or clients identified as NPO).
  - New-to-market is an extended-release formulation.
  - New-to-market is a sprinkle formulation.
- If the new-to-market medication is a novel product and/or requires extensive monitoring, a prior authorization will be required. The prescriber should submit the following for review:
  - Current chart notes and/or discharge summary

  - Documentation of all previous therapies tried with treatment timeframe and responses
  - Current labs if warranted (e.g., oncology and hemophilia)
  - Letter of Medical Necessity outlining the rationale for this medication over others currently on the market
- Once the new-to-market medication has been reviewed by the DUR Board, required criteria for approval will be consistent with the DUR Board vote. All new and renewal prior authorization requests will refer to the DUR Board approved criteria.

5) LYRICA® UPDATE AND FIBROMYALGIA

LYRICA® (pregabalin) 25 mg, 50 mg, 75 mg, 100 mg, 150 mg, 200 mg, 225 mg and 300 mg capsules and 20 mg/mL oral solution

INDICATIONS:

- Management of neuropathic pain associated with diabetic peripheral neuropathy
- Management of postherpetic neuralgia
- Adjunctive therapy for the treatment of partial-onset seizures in patients 1 month of age and older
- Management of fibromyalgia
- Management of neuropathic pain associated with spinal cord injury

UPDATED LYRICA® CRITERIA:

- Remove pregabalin criteria making it available without a PA and add to the neuropathic pain agent list as a preferred agent with criteria.
- Keep therapeutic duplication criteria for all doses of pregabalin and allow one therapeutic duplication (90% overlap of last fill) with different date of service and same prescriber ID between Lyrica® GCNs in previous 93 days.
- Add therapeutic duplication criteria with gabapentin.
- Keep previous quantity edits with a maximum daily dose of 600 mg/day for pregabalin IR.
- Pregabalin ER will remain non-preferred with manual review requiring documentation of the medical necessity over the IR formulation.

UPDATE TO NEUROPATHIC PAIN AND FIBROMYALGIA AGENTS:

- Remove fibromyalgia class from PDL and incorporate into the neuropathic pain class

EFFECTIVE DECEMBER 1, 2021

6) POLYPHARMACY EDITS

The recently-enacted Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act includes measures to combat the opioid crisis in part by reducing opioid abuse and misuse by advancing treatment and recovery initiatives, improving prevention, protecting communities, and bolstering efforts to fight deadly illicit synthetic drugs. There are several Medicaid-related DUR provisions contained within Section 1004 of the SUPPORT Act with respect to FFS and MCO pharmacy programs. These provisions establish drug review and utilization standards to supplement existing requirements under Section 1927(g) of the Act, in an effort to reduce opioid-related fraud, abuse and misuse.

Per Section 1004 of the SUPPORT Act, state Medicaid programs use prospective safety edits and comprehensive retrospective claims review processes for implementing opioid limitations on initial and

subsequent prescription refills. The Act also outlines the requirement to monitor for concurrent opioid/benzodiazepine usage and opioid/antipsychotic usage.

PROPOSED ACTION:

- For the above drug combinations, add a POS prospective review
    - Opioid—benzodiazepine
    - Opioid—sedative hypnotic
    - Opioid—muscle relaxer
    - Opioid—antipsychotics
    - Opioid—gabapentin
- The pharmacist would be required to review the rejection and apply the proper DUR codes if they feel the combination is appropriate.
- Opioids include buprenorphine products.
- Example messages to pharmacists
    - *TOXICITY WARNING- Perform DUR Review; Enter appropriate codes*
    - *DD – Caution Risk of breathing difficulties with combination of these medications. Review & submit appropriate DUR codes*

EFFECTIVE IMMEDIATELY

7) VERQUVO™ (vericiguat) 2.5 mg, 5 mg, and 10 mg tablets

INDICATION:
VERQUVO is a soluble guanylate cyclase (sGC) stimulator, indicated to reduce the risk of cardiovascular death and heart failure (HF) hospitalization following a hospitalization for heart failure or need for outpatient IV diuretics, in adults with symptomatic chronic HF and ejection fraction less than 45%.

TREATMENT OF HEART FAILURE WITH SECONDARY AGENTS:
Long-term initial pharmacologic therapy for Heart Failure With Reduced Ejection Fraction (HFrEF) includes a diuretic (as needed to treat volume overload), a renin-angiotensin system antagonist (an angiotensin receptor-neprilysin inhibitor [ARNI], angiotensin converting enzyme [ACE] inhibitor, or single agent angiotensin receptor blocker [ARB]), and a beta blocker. If a patient is unable to take any of the renin angiotensin system antagonists due to contraindications, the combination of hydralazine plus an oral nitrate is an alternative. Thus, initial therapy for each patient with HFrEF generally includes three types of drugs.

Secondary pharmacologic therapy for HFrEF is added to optimal initial pharmacologic therapy for patients who meet specific criteria. If symptoms persist on initial therapy plus mineralocorticoid receptor antagonist (if indicated), add one or more additional agents, as indicated. The options for additional drug therapy are an SGLT2 inhibitor (choice of agent described in this section), vericiguat, ivabradine, hydralazine plus nitrate, and digoxin. The choice of which drug to add next is based upon evidence of efficacy, criteria for use, contraindications, risks of adverse drug effects and patient compliance.

APPROVAL CRITERIA

- Recipient must be ≥ 18 years of age; **AND**
- Recipient must be diagnosed with symptomatic chronic heart failure (**New York Heart Association class III-IV**) with an ejection fraction < 45% following a worsening HF event **OR** a diagnosis consistent with FDA-approved indications; **AND**

- Recipient must have previously been hospitalized for heart failure in the last 6 months or required outpatient IV diuretics in the last 3 months; **AND**
- Recipient must remain on standard of care therapy; **AND**
- Recipient of reproductive potential should use contraception and have a negative pregnancy test; **AND**
- Recipient has continued heart failure symptoms while on Entresto®; **AND**
- Prescriber must submit the following:
    - Current chart notes; **AND**
    - Discharge summary from hospital if recently hospitalized; **AND**
    - Documentation of previous therapies tried with outcomes; **AND**
    - Documentation of ejection fraction; **AND**
    - Pro-BNP confirms heart failure diagnosis; **AND**
    - Negative pregnancy test results for recipients of reproductive potential

DENIAL CRITERIA

- Recipient does not meet approval criteria **OR** have a diagnosis supported on the official Compendia; **OR**
- Recipient is pregnant; **OR**
- Recipient is taking another soluble guanylate cyclase (sGC) stimulator (i.e., Adempas); **OR**
- Recipient taking a PDE-5 inhibitor is not recommended to take with this product; **OR**
- Recipient has severe hepatic impairment (Child-Pugh C) or severe renal impairment (eGFR <15 mL/min/1.73m^2 or on dialysis)

CONTINUATION CRITERIA

- Prescriber must submit the following:
    - Current chart notes; **AND**
    - Documentation of response to therapy; **AND**
- Recipient has an improvement in symptoms (i.e., EF, quality of life)

QUANTITY EDITS
#31/ 31 days for each strength

EFFECTIVE IMMEDIATELY

8) FOTIVDA® (tivozanib) 0.89 mg and 1.34 mg capsules

INDICATION:
FOTIVDA is indicated for the treatment of adult patients with relapsed or refractory advanced renal cell carcinoma (RCC) following two or more prior systemic therapies.

APPROVAL CRITERIA

- Recipient must be ≥ 18 years of age; **AND**
- Recipient must have a diagnosis of relapsed or refractory advanced renal cell carcinoma **OR** a diagnosis consistent with FDA-approved indications; **AND**
- Recipient must have had two or more prior systemic therapies including at least one VEGFR kinase inhibitor (e.g., axitinib); **AND**
- Prescriber must submit the following:

  - Current chart notes; **AND**
  - Documentation of previous therapies tried; **AND**
  - Documentation of current blood pressure (monitor often during therapy); **AND**
  - Current labs including CBCs and LFTs; **AND**
- Initial approval for 1 month

DENIAL CRITERIA
- Recipient does not meet approval criteria **OR** have a diagnosis supported on the official Compendia; **OR**
- Recipient has systolic blood pressure ≥ 150 mmHg or diastolic blood pressure ≥ 100 mmHg despite anti-hypertensive therapy; **OR**
- Recipient had a severe or life-threatening venous or arterial thromboembolic event; **OR**
- Recipient had a severe or life-threatening hemorrhagic event; **OR**
- Recipient develops nephrotic syndrome/proteinuria; **OR**
- Recipient develops reversible posterior leukoencephalopathy syndrome; **OR**
- Recipient had a major surgery < 2 weeks prior to request; **OR**
- Recipient is pregnant or breastfeeding; **OR**
- Recipient with moderate hepatic impairment requires a dose reduction

CONTINUATION CRITERIA
- Recipient has no unacceptable toxicity; **AND**
- Prescriber must submit the following
  - Current chart notes with documentation of response to therapy; **AND**
  - Current labs including LFTs and CBCs; **AND**
  - Documentation of blood pressure

QUANTITY EDITS
#21/28 day

EFFECTIVE IMMEDIATELY

9) LUMAKRAS™ (sotorasib) 120 mg tablet

INDICATION:
- Indicated for the treatment of adult patients with KRAS G12C-mutated locally advanced or metastatic non-small cell lung cancer (NSCLC), as determined by an FDA-approved test, who have received at least one prior systemic therapy.

- This indication is approved under accelerated approval based on overall response rate (ORR) and duration of response (DOR). Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial(s).

APPROVAL CRITERIA
- Recipient must be ≥ 18 years of age; **AND**
- Recipient must have a diagnosis of KRAS G12C-mutated locally advanced or metastatic non-small cell lung cancer who have received at least one prior systemic therapy **OR** a diagnosis consistent with FDA-approved indications; **AND**
- Prescriber must submit the following:

  - Current chart notes; **AND**
  - Current labs including LFTs; **AND**
  - Test results verifying the KRAS G12C mutation from tumor or plasma specimens; **AND**
  - Documentation of previous therapies tried including an immune checkpoint inhibitor (anti-PD-1/PD-L1) (e.g., pembrolizumab, atezolizumab) and/or platinum-based chemotherapy (e.g., cisplatin, carboplatin); **AND**
- Initial PA for maximum of 3 months

DENIAL CRITERIA
- Recipient does not meet approval criteria **OR** have a diagnosis supported on the official Compendia; **OR**
- Recipient requires acid-reducing agents (PPIs or H_2 receptor antagonists) or a strong CYP3A inducer (e.g., phenytoin or rifampin) due to a decrease in sotorasib concentration; **OR**
- Recipient requires a CYP3A4 substrate (e.g., cyclosporin or ketoconazole) due to a decrease in plasma concentration of the substrate or a P-glycoprotein substrate (e.g., digoxin) due to an increase in plasma concentration of the substrate; **OR**
- Recipient cannot tolerate the minimum dose of 240 mg daily; **OR**
- Recipient has confirmed interstitial lung disease/pneumonitis; **OR**
- Recipient is pregnant or breastfeeding

CONTINUATION CRITERIA
- Recipient has no unacceptable toxicity; **AND**
- Prescriber must submit the following
  - Current chart notes with documentation of response to therapy; **AND**
  - Current labs including LFTs

QUANTITY EDITS
#248/ 30 days

EFFECTIVE IMMEDIATELY

10) EMPAVELI™ (pegcetacoplan) 1,080 mg/20 mL injection

INDICATION:
EMPAVELI™ is a complement C3 inhibitor indicated for the treatment of adult patients with paroxysmal nocturnal hemoglobinuria (PNH).

REQUIRES ENROLLMENT IN THE REMS PROGRAM:
The purpose of the EMPAVELI REMS is to mitigate the occurrence and morbidity associated with encapsulated bacterial infections (*Streptococcus pneumoniae*, *Neisseria meningitidis* types A, C, W, Y, and B, and *Haemophilus influenzae* Type B) by educating healthcare providers and patients about:

- the potential risk of infections caused by encapsulated bacteria with EMPAVELI
- the need for vaccination and antibiotic prophylaxis, if required
- the early signs of invasive encapsulated bacterial infections, and
- the need for immediate medical evaluation of signs and symptoms consistent with possible encapsulated bacterial infections

APPROVAL CRITERIA

- Recipient must be ≥ 18 years of age; **AND**
- Recipient must have a diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) **OR** a diagnosis consistent with FDA indications; **AND**
- Recipient must be vaccinated against encapsulated bacteria, including *Streptococcus pneumoniae*, *Neisseria meningitidis* types A, C, W, Y, and B, and *Haemophilus influenzae* type B at least 2 weeks prior to initiation of EMPAVELI, and recipient must be provided antibiotics if vaccines were administered less than 2 weeks before starting therapy; **AND**
- Prescriber, pharmacy, and recipient must be enrolled in the REMS program; **AND**
- Recipient currently taking eculizumab (Soliris®) or ravulizumab (Ultomiris®) must follow the required dose initiation per the package insert; **AND**
- Recipients taking eculizumab (Soliris®) or ravulizumab (Ultomiris®) must have been stable for at least 3 months; **AND**
- Female recipients of reproductive potential should use contraception and have a negative pregnancy test prior to starting therapy; **AND**
- Recipient's baseline hemoglobin level is <10.5 g/dL; **AND**
- Treatment naïve recipient's (no previous C5 inhibitor or C3 inhibitor) baseline lactate dehydrogenase (LDH) level is elevated; **AND**
- Prescriber must submit the following:
    - Current chart notes; **AND**
    - Documentation of previous therapies; **AND**
    - Current labs including CBC and LDH; **AND**
    - Pregnancy test results (if applicable)

DENIAL CRITERIA

- Recipient does not meet approval criteria **OR** have a diagnosis supported on the official Compendia; **OR**
- Recipient has not been vaccinated according to package insert/REMS requirements; **OR**
- Recipient has an unresolved serious infection caused by encapsulated bacteria; **OR** including *Streptococcus pneumoniae*, *Neisseria meningitidis*, and *Haemophilus influenzae*
- Recipient is pregnant or breastfeeding

CONTINUATION CRITERIA

- Recipient is compliant on therapy; **AND**
- Recipient has an improvement in hemoglobin and/or LDH levels compared to baseline; **AND**
- Recipient with continued LDH > 2X ULN should adjust dose to 1,080 mg every 3 days; **AND**
- Recipient has an improvement in overall clinical presentation (e.g., fatigue, dyspnea); **AND**
- Prescriber must submit the following:
    - Current chart notes; **AND**
    - Current labs CBC and LDH

QUANTITY EDITS

10 vials/ 30 days

EFFECTIVE IMMEDIATELY

11) TRUSELTIQ™ (infigratinib) 50 mg, 75 mg, 100 mg, and 125 mg 21-day pack

INDICATION:
TRUSELTIQ is indicated for the treatment of adults with previously treated, unresectable locally advanced or metastatic cholangiocarcinoma with a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test.

This indication is approved under accelerated approval based on overall response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial(s).

APPROVAL CRITERIA

- Recipient must be ≥ 18 years of age; **AND**
- Recipient has a diagnosis of previously treated, unresectable locally advanced or metastatic cholangiocarcinoma with a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test **OR** diagnosis consistent with FDA indications; **AND**
- Recipient has progressed after at least 1 failed prior systemic therapy. Provide the medical necessity of infigratinib over FOLFOX. Provide documentation of that therapy including any radiation with response; **AND**
- Prescriber should submit the following:
    - Current chart notes with previous therapies tried; **AND**
    - Documentation of FGFR2 fusion or other rearrangement; **AND**
    - Current labs including serum phosphate (initiate phosphate lowering therapy if >7.5 mg/dL with reduction in dose), CBC, LFTs; **AND**
    - Documentation of comprehensive ophthalmological exam; **AND**
    - Pregnancy test results for recipient with child-bearing potential; **AND**
- Initial PA for 2 months.

DENIAL CRITERIA

- Recipient does not meet the above approval requirements; **OR**
- Recipient is unable to tolerate 50 mg once daily; **OR**
- Recipient has persistent symptoms for Retinal Pigment Epithelial Detachment (RPED); **OR**
- Recipient has life-threatening consequences due to elevated serum phosphate; **OR**
- Recipient requires concomitant strong or moderate CYP3A inhibitors (e.g., itraconazole, erythromycin, verapamil); if cannot be avoided, reduce Truseltiq™ dose; **OR**
- Recipient requires strong or moderate CYP3A inducer (e.g., carbamazepine, phenytoin); **OR**
- Recipient is pregnant

CONTINUATION CRITERIA

- Recipient must not experience unacceptable toxicity; **AND**
- Prescriber should submit the following:
    - Follow-up ophthalmological exam at the following intervals—1 month, 3 months, then every 3 months thereafter during treatment; **AND**
    - Current chart notes with response to therapy; **AND**
    - Current labs including serum phosphate; **AND**

- Recipient is not pregnant or breastfeeding

QUANTITY EDITS

- 1 dose pack per 21 days

12) FRIENDLY REMINDERS

1. Any questions concerning various Medicaid topics (e.g., Medicaid enrollment, prescription coverage, provider manuals, and billing policies) may be researched using one of the following links.
   - **https://medicaid.mmis.arkansas.gov/**
   - **https://humanservices.arkansas.gov/**
   - **https://arkansas.magellanrx.com/**

   Any questions about prescription drugs or drug claims for PASSE members must be directed to the specific PASSE organization taking care of that member. For more information about PASSE, please refer to the website:
   https://humanservices.arkansas.gov/about-dhs/dms/passe/
   For questions about each PASSE organization, please refer to this website for contact information:
   https://humanservices.arkansas.gov/about-dhs/dms/passe/contact-us

2. **MAT (Medication Assisted Treatment) with buprenorphine/naloxone and psychosocial treatment or counseling:** Per the TIP 40: *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction*: *Treatment Improvement Protocol (TIP) Series 40*: "Pharmacotherapy alone is rarely sufficient treatment for drug addiction. For most patients, drug abuse counseling—individual or group—and participation in self-help programs are necessary components of comprehensive addiction care. As part of training in the treatment of opioid addiction, physicians should at a minimum obtain some knowledge about the basic principles of brief intervention in case of relapse. Physicians considering providing opioid addiction care should ensure that they are capable of providing psychosocial services, either in their own practices or through referrals to reputable behavioral health practitioners in their communities."

   http://lib.adai.washington.edu/clearinghouse/downloads/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction-54.pdf

3. **For vaccine billing and updates, visit the Welcome to Arkansas webpage.**
   https://humanservices.arkansas.gov/
   https://humanservices.arkansas.gov/covid-19/dhs-response-to-covid-19/updates-for-providers/
   For adult vaccines (ages 18 and above), the following HCPCS and CPT codes are to be used in conjunction with the vaccine being administered:
   G0008 – Influenza immunization
   90471 – First vaccine administered
   90472 – Subsequent vaccines administered
   The **Injection administration code, T1502** will continue to be payable for clients of all ages. **T1502** may be used for billing the administration of subcutaneous and/or intramuscular injections only.
   If you have questions regarding this notice, please contact the Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and out-of-state at (501) 376-2211.
   Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rulemaking, and remittance advice (RA) messages are available for download from the Arkansas Medicaid website:
   https://medicaid.mmis.arkansas.gov/Provider/Docs/Docs.aspx/
   If assistance is needed with a Medicaid vaccine or immunization billing issue, the MMIS outreach specialists are available to help. Please refer to this website to find the outreach/provider rep for your pharmacy:
   https://afmc.org/health-care-professionals/arkansas-medicaid-providers/mmis-outreach-specialists/

4. **INCARCERATED PERSONS:**
   The Medicaid Pharmacy Program is prohibited by federal regulations, 42 C.F.R. §435.1009 and §435.1010, from paying for drug claims for Medicaid clients who, on the date the prescription is filled, is incarcerated in a correctional or holding facility, including juvenile correctional facilities, and are detained pending disposition of charges, or are held under court order as material witnesses. If medications are requested for incarcerated Medicaid clients, including clients in a juvenile correctional facility, **the medications cannot be billed to Medicaid Pharmacy Program and are**

subject to recoupment if billed to Medicaid. Pharmacists should contact the correctional facility regarding the facility's reimbursement procedures for the requested medications.

5. **Suboxone Film (buprenorphine/naloxone) once daily dosing:** as stated in the Suboxone Film package insert, the FDA approved dose for treating opioid addiction is prescribing the total daily dose as one single daily dose. "After treatment induction and stabilization, the maintenance dose of SUBOXONE sublingual film is generally in the range of 4 mg/1 mg buprenorphine/naloxone to 24 mg/6 mg buprenorphine/naloxone per day depending on the individual patient and clinical response. **The recommended target dosage of SUBOXONE sublingual film during maintenance is 16 mg/4 mg buprenorphine/naloxone/day as a single daily dose**. Dosages higher than 24 mg/6 mg daily have not been demonstrated to provide a clinical advantage."

6. **REGARDING MANUAL REVIEW PA REQUESTS:** Prior authorization (PA) requests for drugs that require a clinical manual review prior approval, require a prior authorization request for a drug as an exception to established point of sale prior approval criteria algorithm, or require a request for non-preferred drugs on the PDL, are all reviewed on a case-by-case basis through a manual review process. All manual review requests for prior authorization require, at a minimum, the prescriber to provide a letter explaining the medical necessity for the requested drug along with all written documentation to substantiate the medical necessity, e.g., chart notes, pharmacy printouts for cash, printout of private insurance paid drugs, lab results, etc. **Please note that starting the requested drug, including long-acting injectable antipsychotic agents, through either inpatient use, the use of office "samples", or by any other means, prior to a prior authorization request being reviewed and approved by the Medicaid Pharmacy Program does not necessitate Medicaid Pharmacy Program approval of the requested drug.**

7. **REGARDING EMERGENCY OVERRIDE**: In an emergency, for those drugs for which a five-day supply can be dispensed, an Arkansas Medicaid enrolled pharmacy provider may dispense up to a five-day supply of a drug that requires prior authorization (e.g., a drug that requires a clinical PA or requires a PA for a non-preferred drug). **This provision applies only in an emergency when the MMA Prescription Drug Help Desk and the State Medicaid Pharmacy Program offices are closed, and the pharmacist is not able to contact the prescribing provider to change the prescription.** The Emergency Supply Policy does not apply to drugs that are not covered by the State. Frequency of the emergency override is limited to once per year per drug class for non-LTC clients and once per 60 days per drug class for LTC clients.

   To submit a claim using this emergency provision, the pharmacy provider must submit "03" in the Level of Service (418-DI) field. For any Schedule-II controlled substance filled using the Medicaid Emergency Override process, please refer to the Arkansas State Board of Pharmacy regulations regarding partial fill of a Schedule-II controlled substance. See information posted on the Medicaid Pharmacy Program website, https://arkansas.magellanrx.com/provider/documents/.

8. **HARD EDIT ON EARLY REFILL:**

   Non-controlled drugs:
   The hard edit disallowing early refills (ER) for non-controlled drugs sooner than 75% of days' supply expended was implemented on February 16, 2016. Pharmacies will no longer be able to override the ProDUR early refill edit to refill non-controlled drugs sooner than 75% of the days' supply has elapsed. Refills for non-controlled drugs sooner than 75% of the days' supply elapsed will require a manual review PA, and the pharmacy or prescriber must provide documentation to Medicaid that the dose was increased during the month which caused the prescription to run out sooner than expected/calculated. The increased dose must be within the allowed Medicaid dose edits or an approved PA must be in the system for the client for the higher dose or an early refill PA will not be approved.

   Controlled drugs:
   The hard edit disallowing early refills (ER) for controlled drugs sooner than 90% of days' supply expended was implemented January 20, 2021. This change includes opioids, CII stimulants, benzodiazepines, sedative hypnotics, etc.

9. **REFILL TOO SOON ACCUMULATION LOGIC:** When a pharmacy refills a prescription claim early, the Medicaid system began adding together the accumulated "early days" filled. Each prescription is tracked by the Generic Sequence Number (GSN), which means the drug claim is the same generic name, same strength, and same dosage form, rather than tracking by prescription number or NDC.

Non-controlled drugs:
Once the client has accumulated an *extra* 12 days' supply for that GSN for non-controlled drugs, any incoming claim that is early will reject at point of sale. The accumulation edit is set so that the client cannot accumulate more than an *extra* 12 days' supply early during a 180-day period for non-controlled drugs.

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Controlled drugs:
The RTS logic with Early Refill Accumulation Limit edit for controlled drugs will only allow an *extra* 7-days' supply accumulation through early fills in previous 180-day period.

10. **REVERSE AND CREDIT MEDICAID PRESCRIPTIONS NOT PROVIDED TO CLIENT:** Pharmacies are required to reverse and credit back to Medicaid original prescriptions and refills if the medication was not provided to the client. Pharmacies should reverse and credit Medicaid within 14 days of the date of service for any prescription that was not provided to the client. See the Provider Manual Update Transmittal or the Pharmacy Provider Manual Section 213.200.

11. **ANTIPSYCHOTIC AGENT CRITERIA FOR CHILDREN:**

< 18 YEARS OF AGE:
Each new start of any antipsychotic agent for children < 18 years of age require a completed/signed informed consent form, current metabolic labs, and documentation of medical necessity with chart notes. Clients have an ongoing requirement for labs for metabolic monitoring every 6 months. When any provider sends a patient, who is less than 18 years of age for the required metabolic labs for the antipsychotic agents, the provider must include the PCP's name and Medicaid ID number on the lab order request form. It does not have to be the PCP ordering the labs. Please refer to the Physician/Independent Lab/CRNA/Radiation Therapy Center Provider Manual, Section II, 245.000 B.

For those providers who have not had their own version of the Informed Consent form approved for use with Medicaid PA requests and who use the Medicaid Informed Consent form for antipsychotic agents, the form may be found at the following link. https://arkansas.magellanrx.com/client/docs/rxinfo/MedInformedConsent.pdf

< 10 YEARS OF AGE:
Medicaid currently requires a manual review PA of any antipsychotic agent prescribed for children less than 10 years of age (i.e., age 9 years and under) for all new starts on an antipsychotic agent, including a change in the chemical entity for children currently on an antipsychotic agent. All documentation, chart notes, signed informed consent, and required lab work must be submitted, and the manual review will be performed by the Medicaid Pharmacy Program psychiatrist.

12. **THE AR MEDICAID PHARMACY PROGRAM REIMBURSES ENROLLED PHARMACY PROVIDERS FOR COVERED OUTPATIENT DRUGS FOR MEDICAID CLIENTS WITH PRESCRIPTION DRUG BENEFITS:** Only medications prescribed to that client can be billed using the client's Medicaid ID. If medications are needed to treat remaining family members, each prescription must be billed accordingly to each family member's Medicaid ID number. Sanctions may be imposed against a provider for engaging in conduct that defrauds or abuses the Medicaid program. This could include billing a child's medication to a parent's Medicaid ID number and vice-versa.

13. **ANY REIMBURSEMENT RATES STATED IN THIS MEMORANDUM (OR ANY PREVIOUS MEMORANDUMS) ARE FOR REFERENCE PURPOSES ONLY AND SUBJECT TO CHANGE:** AR Medicaid Pharmacy Program reimbursement methodology changed based on the requirements in the Affordable Care Act (ACA) and requirements of §447.502 of the final regulation and based on the CMS imposed final implementation date of April 1, 2017. The pricing methodology is lesser of methodology that applies to all brand or generic drugs for usual and customary charge, or NADAC, or ACA FUL, or SAAC. If the NADAC is not available, the allowed ingredient cost shall be WAC + 0%, SAAC, or ACA FUL. The Professional Dispensing Fee has been increased to $9 for Brand Drugs and $10.50 for Preferred Brand Drugs and all Generics. Reimbursement rates stated in this memo are in no way a contractual obligation by Arkansas Medicaid. NADAC pricing is subject to change and any pricing stated is only current as of the date this memo was drafted. Current Generic Upper Limits (GUL) or Maximum Allowable Cost (MAC) that have been issued at the State and or Federal level, along with State issued Capped Upper Limits (CAP), can be found on the Arkansas Medicaid website: https://arkansas.magellanrx.com/provider/documents/ A coversheet for the NADAC Help Desk Request for Medicaid Reimbursement Review form can be found on the Arkansas Medicaid website:

https://arkansas.magellanrx.com/client/docs/rxinfo/ARRx_NADAC_Request_Medicaid_Reimbursement_Review_Form.pdf

14. **ELECTRONIC PROVIDER MEMO:** To reduce paper waste beginning April 2019, Arkansas Medicaid will no longer mail Pharmacy Program Provider Memos. An electronic message will be sent to all Medicaid enrolled prescribing providers and pharmacy providers as an alert message when the complete Provider Memo is posted on the Arkansas Medicaid Pharmacy Program website.

    NOTE: To ensure you receive the notification email, please verify that your email is correct in the Arkansas Medicaid provider portal. Department of Human Services correspondence would also be included in this effort to reduce paper waste. To ensure that all correspondence is received, we ask that each provider verify that the provider portal has the correct email address used for your business communications.

    The Arkansas Medicaid Pharmacy Program Provider Memos can be found at https://medicaid.mmis.arkansas.gov/Provider/Provider.aspx. To access the memos, select the OTHER LINKS drop-down menu in the upper-left corner of the screen, click MAGELLAN MEDICAID ADMINISTRATION, select the ADMINISTRATOR box, select the RESOURCES drop-down menu in the upper-right corner, click DOCUMENTS, select the PHARMACY tab in the top row of tabs, and then click MEMORANDUMS. The Memo can also be found at: https://arkansas.magellanrx.com/provider/documents/. To access the memos, select the PHARMACY tab and then click MEMORANDUMS.

    An added benefit of viewing the Medicaid Pharmacy Program Provider Memo online is the search feature, which will allow a more accessible and efficient user experience. To use this feature, use the shortcut by pressing the Ctrl + F keys, enabling a keyword search. Starting with the January 2018 memo, the online versions of the Provider Memos will also contain active hyperlinks in the Table of Contents. To activate these hyperlinks, open the Provider Memo, hover the mouse over the Table of Contents, press the Ctrl key until the mouse cursor (“hand”) appears, then place the cursor on the item desired and click the mouse. The hyperlink in the Table of Content will then redirect to the corresponding chapter of the Provider Memo.

15. **OPIOID INFORMATION ON THE MAGELLAN WEBSITE:** To provide educational materials to prescribers and pharmacists on opioid dosing, opioid use disorder, medication assisted treatment and polypharmacy, an opioid information tab has been added to the Magellan Health website.
    https://arkansas.magellanrx.com/client/documents

16. **HEPATITIS C TREATMENT INFORMATION**

    Educational information on treating Hepatitis C along with treatment consultations may be obtained through the Clinician Consultation Center.

    1) Link for the Clinician Consultation Center—http://www.hepcap.org/hepatitis-c-consultation-warmline/
    2) Hepatitis C Warmline for phone consultation—(844) HEP-INFO or (844) 437-4636

    The clinical consultation staff may give advice on any of the following topics:

    - HCV staging & monitoring
    - Regimen selection & dosing
    - Drug interactions
    - HIV/HCV management strategies
    - Prior HCV treatment failure, including management of complex clinical problems such as cirrhosis and renal disease
    - HCV transmission & prevention
    - HCV screening & diagnostic testing
    - HCV in special populations (pregnancy, co-occurring substance use and/or alcohol use disorders, psychiatric disorders, post-transplant, ESRD/dialysis, pediatrics)

    The Clinician Consultation Center is not affiliated with Arkansas Medicaid, but the information may be useful for providers in our state and provided only as an educational tool.

This advance notice is to provide you the opportunity to contact, counsel, and change patients’ prescriptions.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at 501-320-6429.

If you have questions regarding this transmittal, or you need this material in an alternative format such as large print, please contact the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895. For copies of past Remittance Advices (RA) or Arkansas Medicaid Provider Manuals (including update transmittals), please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and out-of-state at 1-501-376-2211.